

Installment Agreement

(See Instructions on the back of this page)

Name and address of taxpayer(s)
JERRY MOORE
2253 MERIDIAN RD
LAMAR, MS 38642

Submit a new Form W-4 to your employer to increase your withholding.

Social Security or Employer Identification Number (SSN/EIN)
(Taxpayer) 428-08-2802 (Spouse)

Your telephone numbers (including area code)
(Home) (Work, cell or business)
(901) 497-1291

For assistance, call:
1-800-829-3903 (Individual - Self-Employed/Business Owners, Businesses), or
1-800-829-7650 (Individuals - Wage Earners)

Or write _____
(City, State, and ZIP Code)


Kinds of taxes (form numbers) Tax periods Amount owed as of
FORM 1040 2022-2023 05/29/2024
\$ 12,674

I / We agree to pay the federal taxes shown above, PLUS PENALTIES AND INTEREST PROVIDED BY LAW, as follows
\$ 25 on 07/15/2024 and \$ 25 on the 15th of each month thereafter

I / We also agree to increase or decrease the above installment payments as follows:

Date of increase (or decrease)	Amount of increase (or decrease)	New installment payment amount
07/15/2025	95	120
07/15/2026	100	220

The terms of this agreement are provided on the back of this page. Please review them thoroughly.

 By initialing here and my signature below, I agree to the terms of this agreement, as provided in this form, if it is approved by the Internal Revenue Service.

Additional Conditions / Terms (To be completed by IRS) By signing and submitting this form, I authorize the IRS to contact third parties and to disclose my tax information to third parties in order to process and administer this agreement over its duration.

DIRECT DEBIT — Attach a voided check or complete this part only if you choose to make payments by direct debit. Read the instructions on the back of this page.

a. Routing number

0	7	1	0	0	0	0	1	3
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b. Account number

8	7	7	2	4	5	5	9	7								
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I authorize the U.S. Treasury and its designated Financial Agent to initiate a monthly ACH debit (electronic withdrawal) entry to the financial institution account indicated for payments of my federal taxes owed, and the financial institution to debit the entry to this account. This authorization is to remain in full force and effect until I notify the Internal Revenue Service to terminate the authorization. If I wish to stop payment under my direct debit installment agreement, I may do so by contacting my financial institution either orally or in writing at least three (3) business days before the next scheduled electronic funds transfer. Alternatively, if there are at least fourteen (14) business days before the next scheduled electronic funds transfer, I may contact the Internal Revenue Service at the applicable toll-free number listed above. I also authorize the financial institutions involved in the processing of the electronic payments of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payments.

Debit Payments Self-Identifier

If you are unable to make electronic payments through a debit instrument (debit payments) by providing your banking information in a. and b. above, please check the box below:

I am unable to make debit payments

Note: Not checking this box indicates that you are able but choosing not to make debit payments. See Instructions to Taxpayer below for more details.

Your signature 	Date 05/29/2024	Title (if Corporate Officer or Partner)	Spouse's signature (if a joint liability)	Date
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FOR IRS USE ONLY

AGREEMENT LOCATOR NUMBER: _ _ _ _ _

Check the appropriate boxes:

- RSI "1" no further review AI "0" Not a PPIA
- RSI "5" PPIA IMF 2 year review AI "1" Field Asset PPIA
- RSI "6" PPIA BMF 2 year review AI "2" All other PPIAs

Agreement Review Cycle _ _ _ _ _ Earliest CSED _ _ _ _ _

Check box if pre-assessed modules included

Originator's ID number _____ Originator Code _____

Name _____ Title _____

A NOTICE OF FEDERAL TAX LIEN (Check one box below)

- HAS ALREADY BEEN FILED
- WILL BE FILED IMMEDIATELY
- WILL BE FILED WHEN TAX IS ASSESSED
- MAY BE FILED IF THIS AGREEMENT DEFAULTS

NOTE: A NOTICE OF FEDERAL TAX LIEN WILL NOT BE FILED ON ANY PORTION OF YOUR LIABILITY WHICH REPRESENTS AN INDIVIDUAL SHARED RESPONSIBILITY PAYMENT UNDER THE AFFORDABLE CARE ACT.

Agreement examined or approved by (Signature, title, function) _____ Date _____